1915(c) Medicaid Home and Community-Based Services Waiver for Children with Serious Emotional Disturbance

Operations Manual

Indiana Family and Social Services Administration
Indiana Division of Mental Health and Addiction
Revised February 2005

Introduction

Named after the section of the Social Security Act that authorized it, the 1915c Medicaid Home and Community-Based Waiver Program allows states to design Medicaid funded community-based service programs as alternatives to treatment in long-term care facilities. These HCBS Waivers allow individuals at risk of institutionalization to preserve their independence and ties to family and friends by remaining in their communities.

SED Waiver: In June 2003, Indiana requested a 1915c Waiver from the Centers for Medicare and Medicaid Services for children age 4 through 21, who are eligible for placement in a state psychiatric hospital due to a primary diagnosis of serious emotional disturbance. This waiver application was based upon the recommendations of a year-long Waiver Task Force consisting of parents, advocates, state and local Division of Family and Children, Department of Correction, Department of Education/Division of Exceptional Learners, Office of Medicaid Policy and Planning, providers, Indiana Council of CMHCs, IARCCA, Division of Mental Health and Addiction, and state hospital youth staff.

Indiana's Waiver for Children with Serious Emotional Disturbance ("SED Waiver") was approved by the Centers for Medicare and Medicaid Services (CMS) effective February 1, 2004. CMS approved a maximum of 50 slots for year one of the waiver and a maximum of 200 slots for years two and three, depending on the availability of the required state match.

Available Services: All waiver program participants will receive "Wraparound Facilitation" services.
Other waiver services are:

- Respite Care (if the child receives other waiver or intensive treatment/services);
- Family Support and Training: and
- Independent Skills Training.

Eligibility: The SED Waiver program will eventually be implemented state-wide; however; for the first year, services will be available to children in 10 counties (Daviess, Elkhart, Knox, Lake, Marion, Martin, Pike, Randolph, St. Joseph, and Vigo). Children who are Medicaid recipients and are eligible for placement in a state psychiatric hospital will be offered the choice of participation in SED Waiver programming by their local Community Mental Health Center, if the cost of their care is no greater in the community as it would be in the hospital.

The manual and subsequent revisions will be posted on the web at
www.in.gov/fssa/servicemental/pdf/sedopmanual.pdf

Section 1. Roles and Responsibilities

This section contains brief overviews of entities that have a role in the provision/delivery of SED Waiver services within a system of care.

1.1 Children/Families/Surrogate Families

The SED Waiver program is part of a system of care that is child-centered and family-focused, with the strengths and needs of the child and family driving the treatment planning process and guiding the plan of care. Plans of care should ensure that children and their families can move through the system of services in accordance with their changing needs. No child should be denied access to services based on race, religion, national origin, sex, or physical disability. Services should be sensitive and responsive to cultural differences.

1.2 Community Mental Health Systems of Care

Community Mental Health Centers (CMHCs) as the points of entry to the state hospitals, will serve as the point of entry into SED Waiver programming. (A child is not eligible for SED Waiver programming unless he/she requires the level of care provided by a state psychiatric hospital.) Additionally, CMHCs provide Wraparound Facilitation to SED Waiver program participants and they may be certified to provide other SED Waiver services. A CMHC's eligibility to provide Wraparound Facilitation is based upon the level of local system of care development in each CMHC area.

1.3 Service Providers

Service providers are agencies/entities that apply for certification as providers of a waiver service(s) through DMHA, meet the qualifications to provide the specific waiver service(s), and are enrolled as Medicaid Waiver providers. Waiver service provider agencies or individuals who otherwise meet the requirements may become Medicaid providers and bill directly for services. Agencies and individuals may also be subcontracted by the Community Mental Health Center serving as a fiscal intermediary.

Service providers are authorized to provide specific services as outlined on the waiver participant's Plan of Care/Cost Comparison Budget by the Community Mental Health Center *Wraparound Facilitator*. Service providers must update their qualifications annually with the Division of Mental Health and Addiction to remain certified as Medicaid Waiver providers.

1.4 Division of Family and Children

Individuals who are determined to meet the "level of care" eligibility criteria to enter a state hospital but choose to receive SED Waiver services as an alternative to hospitalization must also receive Medicaid before services can be started. If an SED Waiver applicant is not already on Medicaid or is not on Medicaid Disability, he/she or the parent/guardian must apply for a determination of eligibility for Medicaid Disability. This application for Medicaid may be facilitated by the Community Mental Health Center staff and processed through the Division of Family and Children (DFC) Central Enrollment Unit (CEU) (Section 5.2.1).

1.5 Indiana Division of Mental Health and Addiction

The Indiana Division of Mental Health and Addiction (DMHA) through an interagency agreement with the Office of Medicaid Policy and Planning (OMPP), has the responsibility for operating the SED Waiver. DMHA personnel will develop SED Waiver policy within Federal and State law; certify providers and assist with provider issues; write the waiver application, renewals, and amendments; monitor quality and cost-neutrality; provide required expenditure reports to CMS; and make provisions for technical support.

1.6 Technical Assistance Center

The Technical Assistance (TA) Center for Systems of Care and Evidence Based Practices for Children and Families, through a contract with DMHA, provides technical assistance, training, coaching, and modeling to communities interested in developing a system of care. Assistance includes training opportunities; an annual conference; newsletter; consultation to families and child serving agencies; and a web-based group that provides the opportunity for individuals and agencies to share information and receive support. (1-888-KIDWRAP or www.kidwrap.org)

1.7 Electronic Data Systems (EDS)

Electronic Data Systems is the Indiana Medical Assistance Program (Medicaid) contractor. All bills for Medicaid Waiver services are submitted to and paid by EDS. EDS staff enrolls certified waiver providers into the Indiana Health Coverage Program (Medicaid), develops and write provider manuals, and provides technical assistance. (www.indianamedicaid.com)

1.8 Indiana Office of Medicaid Policy and Planning

The Office of Medicaid Policy and Planning (OMPP) exercises administrative discretion in the administration and supervision of the SED Waiver and the policies, rules and regulations related to the waiver.

1.9 The Centers for Medicare and Medicaid Services (CMS)

The Centers for Medicare and Medicaid Services (CMS) under the U.S. Department of Health and Human Services, is the Federal agency that administers the Medicare and Medicaid programs, which provide health care to the aged, disabled and indigent populations. (In Indiana, the Medicaid program serves indigent families, children, pregnant women, senior citizens, persons with disabilities, and persons who are blind.) CMS reviews all waiver requests/applications, renewals, amendments, and financial reports. Additionally, CMS performs management reviews of all Home and Community-Based Services (HCBS) Waivers to ascertain their effectiveness, safety, and cost-effectiveness. The SED Waiver will receive a CMS management review in 2005.

Section 2. Service Definitions

There are four (4) SED Waiver services available for children who are receiving services under the SED Waiver:

- Wraparound Facilitation
- Respite Care
- Family Support and Training
- Independent Living Skills

Waiver services are provided in addition to other EPSDT or regular Medicaid State Plan services that the program participant needs.

2.1 Duplication of Services

Two of the waiver services may seem to resemble services available to children who are receiving services through the Community Mental Health Rehabilitation Option (MRO). These services are: ADL Training (Independent Living Skills on the SED Waiver); and Case Management (Wraparound Facilitation on the SED Waiver). Waiver services may not duplicate or supplant other Medicaid services.

2.1.1 MRO

Children may receive both MRO and SED Waiver services. MRO Case Management Services and Wraparound Facilitation may both be provided to a program participant; however, activities performed by the Wraparound Facilitator may not be duplicated by the MRO Case Manager (and vice versa). If both services are provided to a program participant, the need for each form of case management must be clearly documented in the Plan of Care to assure that services are not duplicated. The Waiver Wraparound Facilitator is responsible for monitoring services to prevent duplication. The MRO Case Manager must coordinate the provision of services with the Wraparound Facilitator.

2.1.2 Hospice

Waiver program participants who elect to use the Indiana Health Care Program Hospice benefit do not have to disenroll from their waiver program; however, they must come under the direct care of the hospice provider for those services held in common by both programs. In short, the waiver member who elects the hospice benefit may still receive waiver services that are not related to the terminal condition and are not duplicative of hospice care. The hospice provider and the Wraparound Facilitator must collaborate and communicate regularly to ensure the best possible overall care to the waiver/hospice member.

2.2 Wraparound Facilitation

This service includes assessment (with full participation of the child/family/caretaker) to determine community-based services (waiver and non-waiver) needed by the child/family/caretaker to ensure health and safety in the home and community, taking into consideration the child/family's strengths and challenges. The Wraparound Facilitator will produce an individualized community-based plan that facilitates the child/family's access to formal services and informal community resources and relationships. Wraparound Facilitation includes the identification of specific plan goals, objectives, responsibilities, timeliness, outcomes, performance measures, and costs. This process will emphasize building collaboration and coordination among family, caretakers, service providers, educators, community resources, and addressing systemic barriers to service which threaten the success of the Plan of Care. Wraparound Facilitation promotes flexibility to ensure that appropriate and effective services are delivered to the child and family/caretaker. The Wraparound Facilitator monitors outcomes of services, and facilitates revision of the plan when necessary.

Comparison of Services in State Medicaid Plan and Waiver

Case Management	Wraparound Facilitation
Definition: Services provided on **behalf** of the client. They are goal-oriented activities that assist clients by locating, coordinating, and monitoring necessary care and services appropriate and accessible to the recipient. References: • Indiana Code: 405 IAC5-21-5 • Medicaid Rehabilitation Option Provider Manual 4-10 • Best Practices' MRO Reference & Training Manual pp. 25-35 Types: • Client contact – Face- to-face or telephone • Collateral contact – face-to-face or telephone • Documentation and written correspondence **Activities: (not specific to waiver requirements or services)** • Advocating • Assessing/Reassessing • Treatment Planning • Coordinating Services (non waiver and informal supports) • Referrals (non waiver) • Linking with services (non waiver) • Monitoring services (non waiver) • Coordinating with service providers (non waiver) • Completing reports (non waiver)	**Definition**: Specific the to waiver, this service includes assessment of the child's and family's/caretaker's strengths and needs, formation and facilitation of a child and family team to develop and update a comprehensive plan of care, develop and update a crisis plan with the team, budget and monitor budgeting waiver and other Medicaid services, monitor provision of waiver services, and progress through monthly team meetings and contacts. References**:** • Waiver Application • Waiver Manual • Waiver Bulletins Types: • Client contact – Face- to-face or telephone • Collateral contact – face-to-face or telephone • Documentation and written correspondence **Activities**: (specific to waiver requirements) • Assessing/reassessing • Facilitating monthly Child & Family Team • Developing & Updating Plan of Care • Developing & updating Crisis Plan • Monitoring waiver services • Monitoring progress • Monitoring Medicaid Cost & Budgeting • Completing required waiver documents

2.3 Respite Care

Respite Care is short-term direct care and supervision of the child to relieve the primary caretaker(s). The service is designed to help meet needs of the primary caretakers as well as children. These activities include aid in the home, getting a child to school or program, aid after school, at night, and/or any combination of the above. Respite may be scheduled (planned) or provided in a crisis situation. A maximum of 840 hours a year will be allowed. If the child is in respite care for 5 or more hours a day, Respite Care is reimbursed at a "daily" rate (rather than hourly). Therefore, the Wraparound Facilitator must track the number of hours or Respite Care the child has received, to assure that up to 840 hours are available to them if needed. The child and family must be participating in other intensive treatment and waiver services to qualify for Respite Care. Respite Care may be provided in the following location(s):

1. The child's home or place of residence;
2. Foster home;
3. Group home;
4. Emergency shelter care

Respite Care may be reimbursed by the waiver while the child is in a foster home if not covered by another funding source. **Respite Care must never be utilized as child care while the regular caregiver is working.**

2.4 Family Support and Training

Family Support and Training are services that encourage and maintain the ability of the family to care for the child in the home and community. Services include coaching the family to increase their knowledge and awareness of the child's needs, the process of interpreting choices offered by service providers, and explanations and interpretations of policies, procedures, and regulations that have an impact on the child living in the community. Additionally, this service may include behavioral management training, education aimed at involving families in developing plans of care, as well as education regarding the child's needs and resources, monitoring and evaluation. For purposes of this service, family is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. Family does not include individuals employed to care for the child.

2.5 Independent Living Skills

Independent Living Skills is a service designed to assist children/adolescents in acquiring, maintaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Activities are designed to foster eventual or intended ability to live independently within a community setting. These activities are intended to enhance the

components related to family, school, work, and assistance with development, acquisition, retention, or improvement of skills necessary to enable the individual to reside in a non-institutional setting. This service includes budgeting, shopping, working, engaging in recreational activities with peers, peer-to-peer support, and appropriate work skills to remain in the community. This service will be provided by modeling, direction, and support to children and adolescents.

<table>
<tr><th>Activities of Daily Living (ADL)</th><th>Independent Living Skills</th></tr>
<tr>
<td>
<u>Definition</u>: Services provided for or with the client. This service includes the development of skills such as self-care, daily life management or problem solving skills directed toward eliminating psycho-social barriers, provided through structured interventions for the attainment of goals identified in the individualized treatment plan.

<u>Activities:</u>
• Skill building
• Problem solving
• Training to or assisting with accessing services.
• Training to or assisting with meeting needs.

<u>Key Words: (for documentation)</u>
Aided Engaged Reminded
Assisted Guided Supervised
Coached Helped Supported
Directed Instructed
Taught (not academic instruction)
Demonstrated Modeled Trained
Educated Reinforced

<u>Key Points</u>:
• Face to face only
• May be individual or group
• Focus on skill building
</td>
<td>
<u>Definition:</u> Service designed to assist children/adolescents in acquiring, maintaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings. Activities are designed to foster eventual or intended ability to live independently within a community setting. This service includes budgeting, shopping, working, engaging in recreational activities with peers, peer-to- peer support, and work skills to remain in the community.

<u>Activities:</u>
• Modeling
• Direction
• Support

<u>Note:</u>
Can be provided by non-CMHC providers.
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Section 3. Provider Qualifications

The Family and Social Services Administration has assured the Centers for Medicare and Medicaid Services that the standards of any State licensure and/or certification requirements will be met for services or for individuals furnishing services provided under the waiver.

Each child determined to be eligible for the waiver will be given free choice of qualified providers of each service included in his or her written Plan of Care/Cost Comparison Budget.

Payment for services provided under the SED Waiver must be made directly to the provider of the services. No payment may be made to the recipient or any entity other than the provider of waiver services. This does not rule out payment to an organization which functions as a fiscal intermediary or an organized health care delivery system (OHCDS).

The CMHC which is providing at least one SED Waiver service, may contract with other qualified providers to furnish other waiver services. It is not necessary for each subcontractor of a CMHC to sign a Medicaid Provider Agreement; however, subcontractors must meet the standards under the waiver to provide waiver services for the CMHC. The CMHC receives payment for the provision of the services and reimburses the contractors. Waiver providers may not be restricted to participating only through a fiscal intermediary. Such an arrangement must be voluntary. [*]

Waiver participants must be given a choice of qualified providers in their areas.

3.1 Wraparound Facilitation

Agencies that are accredited by one of the DMHA-approved accreditation organizations will be considered as Wraparound Facilitation provider agencies.

Approved accreditation organizations are:

- AAAHC - Accreditation Association for Ambulatory Health Care;
- URAC - American Accreditation Healthcare Commission;
- CARF - The Rehabilitation Accreditation Commission;
- ACA - Commission on Accreditation for Corrections;
- COA - Council on Accreditation of Services for Families and Children;
- JCAHO - Joint Commission on Accreditation of Healthcare Organizations;
- NCQA - National Committee for Quality Assurance.

Additionally, agencies applying as Wraparound Facilitation providers must document the following:

[*] CMS State Medicaid Manual Part 4 - Services - Section 4442.3

1. Development of the local system of care, including the collaborative cross-agency infrastructure and service delivery using child and family wraparound teams;
2. Funding strategies, including availability of flex funds;
3. History of children and families served by child and family teams, including number, length of service, and target populations and outcomes;
4. Challenges;
5. Level of community support;
6. Current capacity of local services for children and youth;
7. Availability of respite/supportive services for children and families and potential for development;
8. Experience using the institutional level of care screening instrument for the admission of children to state hospitals;
9. Involvement with Technical Assistance Center for Systems of Care;
10. Description of continuum of care including 24-hour crisis intervention;
11. Ability to enroll, reassess, and enter service encounter data for youth served by waiver in the Community Data System.

Wraparound Facilitators must complete DMHA required training. A bachelor's degree in human services or a related field; or other approved (through the accreditation process) work/personal experience in providing direct services or linking of services for children with severe emotional disturbance, in addition to training as a children's mental health case manager as required by 440 IAC 9-2-10 (prefer experience as child case manager). Wraparound Facilitators must have a criminal history screen, a screen with state and local Child Protection Agency registries, and drug screen. They must be supervised by an individual who meets criteria as a qualified mental health professional (QMHP) (405 IAC 5-21-1(c)), who has completed DMHA required training, and they must be affiliated with system of care approved by DMHA.

3.2 Respite Care

Agencies may be certified by DMHA and Medicaid to provide Respite Care if they are accredited by one of the DMHA-approved accreditation organizations, which are:

- AAAHC - Accreditation Association for Ambulatory Health Care;
- URAC - American Accreditation Healthcare Commission;
- CARF - The Rehabilitation Accreditation Commission;
- ACA - Commission on Accreditation for Corrections;
- COA - Council on Accreditation of Services for Families and Children;
- JCAHO - Joint Commission on Accreditation of Healthcare Organizations;
- NCQA - National Committee for Quality Assurance.

At the point of re-accreditation, the agency must provide documentation that waiver services were included in the accreditation survey.

Individual foster homes must provide documentation of licensure and that the respite care program meets the requirements of the Child Welfare Manual, Section 6 - 603.3 and/or 603.4. Respite Care providers that contract with foster homes or emergency shelter homes, must have documentation on-site of the foster home and/or emergency shelter licensure (IC 12-17.4) and that the respite care program meets the requirements of the Child Welfare Manual, Section 6 - 603.3 and/or 603.4.

Agency and non-agency providers not subject to accreditation must provide documentation that they meet all standards under "worker qualifications" (below).

Worker qualifications:

- Must be at least 21 years of age;
- High school diploma or equivalent;
- Work or personal experience with children (preference given to those who have worked with children with severe emotional disturbance);
- Completion of DMHA-approved training program;
- Must be supervised by an individual who meets the criteria for a QMHP;
- Meet criminal history requirements as described in the foster parents licensure standards (Child Welfare Manual 609.21 & 609.22, required by IC 12-17.4-3-4-3), screen with state and local Child Protection Agency registries, and drug screen.
- Individual/provider agency will participate in child-family team meetings.

3.3 Family Support and Training

Agencies may be certified to provide Family Support and Training if they are accredited by one of the DMHA-approved accreditation organizations, which are:

- AAAHC - Accreditation Association for Ambulatory Health Care;
- URAC - American Accreditation Healthcare Commission;
- CARF - The Rehabilitation Accreditation Commission;
- ACA - Commission on Accreditation for Corrections;
- COA - Council on Accreditation of Services for Families and Children;
- JCAHO - Joint Commission on Accreditation of Healthcare Organizations;
- NCQA - National Committee for Quality Assurance.

At the point of re-accreditation, the agency must provide documentation that waiver services were included in the accreditation survey.

Worker qualifications:

- Must have a high school diploma or equivalent (with preference given to individuals who have experience working with children and families);
- At least 21 years old;

- Completion of DMHA-approved training program;
- Must pass criminal history requirements as described in the foster parents licensure standards (Child Welfare Manual 609.21 & 609.22, required by IC 12-17.4-3-4-3), screen with state and local Child Protection Agency registries, and drug screen;
- Individual will participate in child-family team meetings;
- Supervised by an individual who meets criteria for a QMHP.

Agency and non-agency providers not subject to accreditation must provide documentation that they meet all standards listed above under "worker qualifications".

3.4 Independent Living Skills

Agencies may be certified by DMHA and Medicaid to provide Independent Living Skills if they are accredited by one of the DMHA-approved accreditation organizations, which are:

- AAAHC - Accreditation Association for Ambulatory Health Care;
- URAC - American Accreditation Healthcare Commission;
- CARF - The Rehabilitation Accreditation Commission;
- ACA - Commission on Accreditation for Corrections;
- COA - Council on Accreditation of Services for Families and Children;
- JCAHO - Joint Commission on Accreditation of Healthcare Organizations;
- NCQA - National Committee for Quality Assurance.

At the point of re-accreditation, the agency must provide documentation that waiver services were included in the accreditation survey.

Worker qualifications:

- Must be at least 21 years old;
- Minimum of two years working with youth (preference given to experience with youth with SED);
- High school diploma or equivalent;
- Must be supervised by an individual who meets criteria for an approved Medicaid provider; completion of approved training in skill area(s) needed by the youth.
- Meet criminal history requirements as described in the foster parents licensure standards (Child Welfare Manual 609.21 & 609.22, required by IC 12-17.4-3-4-3), screen with state and local Child Protection Agency registries, and drug screen.
- Worker will participate in child-family meetings.
- Worker must be supervised by a QMHP.

Agency and non-agency providers not subject to accreditation must provide documentation that they meet all standards listed above under "worker qualifications".

Section 4. Medicaid Eligibility

Medicaid is a Federal and State funded health care program that pays for medical services provided to individuals who meet specific eligibility requirements (listed below). The program serves families, children, pregnant women, senior citizens, persons with disabilities, and persons who are blind.

Recipients of services under the SED Waiver will meet Medicaid eligibility under the "Aged, Blind, Disabled" or "Employees with Disabilities" (referred to as M.E.D. Works)". County Offices of Family and Children are responsible for the determination and redeterminations of eligibility for Medicaid.

Applications are usually filed with the local OFC in the county where the applicant lives; however, waiver applicants may apply for Medicaid at the same time that they apply for the waiver through the Community Mental Health Center. These applications are forwarded to a Division of Family and Children (DFC) Central Enrollment Unit (CEU) for processing. If the applicant is eligible for Medicaid, the case returns to the local OFC for monitoring continued eligibility.

To be eligible for Medicaid as an individual who is aged, blind or disabled; the individual must meet categorical, non-financial, and financial eligibility requirements. (Medicaid eligibility may be retroactive up to three months prior to the month in which the application was received.)

4.1 Categorical Eligibility

The following five categories receive the full range of Medicaid services. (Financial/non-financial eligibility must also be met.)

- **Aged** - Age 65 and older.
- **Blind** - Generally stated, the definition of blindness in Indiana law is as follows: Central visual acuity of 20/200 or less in the better eye with correction, or a visual field contraction of no more than 20 degrees. Persons receiving Supplemental Security Income (SSI) due to blindness automatically meet this requirement.
- **Disabled** - Generally stated, the definition of disability in Indiana law is as follows: A physical or mental condition that appears reasonably certain to last for a continuous period of at least four years without significant improvement (or result in death), and which substantially impairs the person's ability to work in a useful occupation. Persons who are receiving SSI do *not* automatically meet this requirement.
- **Employees with Disabilities-Referred to as "M.E.D. Works",** covers individuals who are age 16-64 who meet the above definition of Disability, except for the fact that they are employed. (See http://www.in.gov/fssa/healthcare/med/ for additional information on M.E.D. Works.)

Medicaid recipients who are aged, blind, or disabled participate in a primary care case management system known as Medicaid Select. Parents and children receiving Temporary Assistance for Needy Families (TANF) as well as non-TANF pregnant women and children with incomes at (or just about) the poverty level, participate in Hoosier Healthwise (primary care case management or risk-based managed care).

Medicaid recipients who are eligible and choose to receive services through a Medicaid Home and Community-Based Waiver will be disenrolled from the managed care programs once a level of care waiver code has been entered into AIM.

4.2 Non-Financial Eligibility

If an individual fits into one of the previously listed categories, the following eligibility criteria must also be met:

- Must be a resident of Indiana;
- Must be a U.S. citizen or a non-citizen in an eligible immigration status. Except for refugees, parolees, and persons whose deportation is withheld, lawful immigrants who enter the country after August 22, 1996, are not eligible for full Medicaid coverage for 5 years. During that time, however, they may receive coverage for emergency medical care if they meet all other eligibility requirements. Additionally, immigrants who have no proof of legal residence in the U.S. are entitled to emergency services if other eligibility requirements are met;
- Must furnish his/her Social Security number;
- Must assign to the State all rights to medical support and payments for medical care that could be available from any third party such as insurance or a non-custodial parent. Individuals must cooperate in providing information about responsible third parties and obtaining third party payments and medical support, unless the individual establishes good cause for not complying.

4.3 Financial Eligibility

Financial eligibility is based on the income and resources/assets of the individual and his or her spouse.

1. **Income**

   <u>Aged, Blind, Disabled</u>

   Income limits are the same as the maximum benefit payable under the SSI program. Income limits increase in January of each year based on the Social Security cost of living adjustment (COLA). "Countable" income from employment is calculated by subtracting $65 from the gross income and dividing by 2. If the applicant is a child, the income of the child's parents is considered in determining

the financial eligibility unless the child is receiving services under a Home and Community-Based Services Waiver.

Low-Income Families

Income limits are the same as those used in the TANF program, approximately 24% of the federal poverty level.

M.E.D. Works (Employees with Disabilities)

The individual's countable income after certain deductions cannot exceed 350% of the federal poverty level.

2. **Resources**

Aged, Blind, and Disabled

For these categories the resource limits are:

- $1500 Individual; one parent of a child applicant
- $2250 Married couple; two parents of a child applicant

(For the **Aged, Blind, and Disabled** categories, there are many kinds of resources that are not counted: the home, irrevocable funeral trusts, income-producing real estate, real estate that is used to produce food for home consumption, real estate that is being offered for sale or rent at fair market value, resources that were protected by purchasing and using an Indiana partnership long term care insurance policy, and, in most cases, one car. Resources that count include: checking and savings accounts, certificates of deposits, stocks, bonds, and the cash value of most life insurance policies).

M.E.D. Works (Employees with Disabilities)

For this category the resource limits are:
$2000 Individual
$3000 Married Couple
For the above categories, parental resources are exempt.

Low-Income Families

For this category, the resource limit is $1000 for the family.

Section 5. Application and Case Processing

Indiana assures the Centers for Medicare and Medicaid Services that the following requirements for individuals who participate in the home and community-based SED waiver are met:

At Risk:
A child must meet the "level of care" required for placement in a State mental health hospital to be eligible for SED home and community-based waiver services. Therefore, applicants for the SED Waiver must be evaluated to determine if they meet the mental hospital level of care (i.e. are at risk of institutionalization).

Health and Safety:
It must be determined that every program participant can be served safely in the community. This is accomplished in general, through quality assurance program design and application, as well as through plan of care development, monitoring, and provider qualifications, standards, and training.

Cost-Neutrality:
Indiana must demonstrate that average per capita expenditures to Medicaid for the SED Waiver program participants are equal to or less than the average per capita expenditures to Medicaid of institutionalization for a comparable population in a mental health hospital.

Choice:
When an individual is determined to be likely to require a mental health hospital level of care, he/she or the legal representative, must be informed of any feasible alternatives under the waiver and given the choice of either institutional or home and community-based services.

5.1 Request for Application

Individuals/parents/guardians who live in an SED Waiver participating county may apply for the Medicaid Waiver for Children with Serious Emotional Disturbance through a Community Mental Health Center (CMHC) that is in their county of residence. CMHC staff may initiate the application process; or the child/parent/guardian may contact the CMHC and request an appointment to make an application; or they may complete, sign, and date an *Application for Long-Term Care Services - Mental Health Hospital/SED Waiver* and submit it to the CMHC in person, mail, or fax. This form is located at www.state.in.us/icpr/webfile/formsdiv/51550.pdf. A child/guardian has a right to apply regardless of diagnosis, age, severity of the disability, or treatment history.

Within 3 business days of receiving the waiver application for the SED Waiver or contact from the child or guardian, the CMHC staff must contact the child/parent/guardian and discuss the process for determining eligibility for the waiver, inform them of the information that may be needed to determine eligibility, and arrange for a face-to-face interview that must be scheduled to take place within 10 business days with the child and family members.

5.2 Initial Level of Care Assessment

To be eligible to receive waiver services a child must meet mental health hospital level of care. To determine if a child meets a mental health hospital level of care, a qualified staff member from the CMHC must complete a *Mental Health Hospital (Institutional) Level of Care Application Form*. A qualified staff member would be a Qualified Mental Health Professional (QMHP) as defined in 405 IAC 5-21-1 (www.in.gov/legislative/iac/T04050/A00050.PDF.

Information necessary to complete the *Level of Care Application Form* includes the Hoosier Assurance Plan (HAPI-C) and the Achenbach System of Empirically Based Assessment (ASEBA) results. Other information may be obtained through psychiatric, psychological, and medical treatment records, educational records, etc.

The HAPI-C scores must be within the last 30 days of the date of the Level of Care assessment. The ASEBA scores must be within the last 90 days of the Level of Care Assessment.

Through the Level of Care application, the QMHP makes a recommendation regarding eligibility; however, the Office of Medicaid Policy and Planning will make the final determination of Level of Care eligibility.

5.2.1 Level of Care Recommended

If **eligibility for psychiatric hospital is recommended** by the CMHC, the application packet includes:

- The Application for Long-Term Care Services;
- The Level of Care (LOC) Application form;
- The Freedom of Choice form;
- Provisional Plan of Care;
- Transmittal for Medicaid Level of Care Eligibility if LOC application is not submitted through INsite;
- Medicaid Waiver Referral to Division of Family and Children if the child is not a Medicaid recipient;
- Medicaid Application Form 2400 if the child is not a Medicaid recipient
- Medical, social, and psychological records if the child is not a Medicaid recipient or the child is not a Medicaid recipient in the "Disabled" category.

5.2.2 Level of Care Denial Recommended

In the case of a **recommended DENIAL** by the CMHC, the Application packet includes:

- The Application for Long-Term Care Services
- The Level of Care Application form
- Transmittal for Medicaid Level of Care Eligibility if LOC application is not submitted through INsite.

5.3 Medicaid Eligibility

Children will not receive Medicaid services including SED Waiver services until they have been determined to be eligible for Medicaid. If the child is a Medicaid recipient in the Disabled or MED Works category, go to Section 5.5.

If the child is a Medicaid recipient but is **not in the Disabled category**, the CMHC staff must send a *Medicaid Waiver Referral to Division of Family and Children* form which indicates that a category change is needed, in addition to a copy of social, psychological, and medical information with the Level of Care and application packet.

If the child is **not** a Medicaid recipient at the time of his/her application for waiver services and an application for Medicaid has not been filed with the local Office of Family and Children (OFC), the CMHC should emphasize to the individual/guardian that 2 separate eligibility processes will be occurring (Medicaid eligibility and eligibility for waiver services) and that someone from DFC Central Enrollment Unit (CEU) will be contacting them to process the Medicaid application.

Do not take Medicaid applications for children who will be placed on a waiting list. Only Medicaid applications for children who have targeted (obligated) slots should be submitted to DMHA.

1. To facilitate the Medicaid application process the CMHC staff will forward the following to the DMHA Waiver Manager:
    a) the original ***Application for Assistance Form 2400*** (www.state.in.us/icpr/webfile/formsdiv/30465.pdf)completed by the individual/guardian;
    b) a copy of the ***Application for Long-Term Care Services*** (www.state.in.us/icpr/webfile/formsdiv/51550.pdf);
    c) a copy of the ***Level of Care Application*** form;
    d) the ***Medicaid Waiver referral to Division of Family and Children*** form; and
    e) Available psychological, social and medical information.

The CMHC staff may complete all or any part of the *Determination of Disability Social Summary State Form 251B*; however, this is optional. (www.in.gov/icpr/webfile/formsdiv/01111.pdf)

2. The DFC CEU clerk registers the application and assigns a CEU Caseworker. The CEU Caseworker will set an interview date with the applicant/guardian.
3. The CEU Caseworker will interview the applicant/representative by phone and determine financial eligibility for Medicaid. If problems arise, the CEU Caseworker will keep the CMHC staff updated.
4. The CMHC staff provides assistance to the CEU Caseworker in obtaining the necessary information for the disability determination.
5. When notified by the CEU Caseworker that Medicaid is ready to be approved, if the child is approved for level of care and the initial Plan of Care is approved, the CMHC staff or Wraparound Facilitator generates the final, formal *Notice of Action, HCBS Form 5* and submits a copy to the CEU Caseworker.
6. The CEU Caseworker will authorize Medicaid and will notify the CMHC staff. If the child becomes eligible for Medicaid as a result of institutional deeming rules, the Medicaid effective date cannot be earlier than the Level of Care determination date.
7. The CEU transfers the case to the local OFC in the county where the individual resides and will provide the contact information of the local OFC Caseworker and Caseworker Supervisor to the Wraparound Facilitator.

If a Medicaid application **has** been filed with the local OFC:

1. To facilitate the Medicaid application process the CMHC staff will forward the following to the DMHA Waiver Manager:
    a) the original ***Application for Assistance Form 2400*** (www.state.in.us/icpr/webfile/formsdiv/30465.pdf)completed by the individual/guardian;
    b) a copy of the ***Application for Long-Term Care Services*** (www.state.in.us/icpr/webfile/formsdiv/51550.pdf);
    c) a copy of the ***Level of Care Application*** form;
    d) the ***Medicaid Waiver referral to Division of Family and Children*** form; and
    e) Available psychological, social and medical information.

    The CMHC staff may complete all or any part of the *Determination of Disability Social Summary State Form 251B* (www.in.gov/icpr/webfile/formsdiv/01111.pdf) however, this is optional.
2. The CEU clerk registers the application and assigns a CEU Caseworker. The CEU Caseworker sets an interview date with the applicant/guardian.
3. The CEU Caseworker will coordinate processing with the local OFC and in most cases; the application will be transferred to the CEU to finish

processing. The CEU Caseworker will honor the date of the earlier pending application.

4. The CEU Caseworker will interview the applicant/representative by phone and determine financial eligibility for Medicaid. If problems arise, the CEU Caseworker will keep the CMHC staff updated.
5. The CMHC staff provides assistance to the CEU Caseworker in obtaining the necessary information for the disability determination.
6. When notified by the CEU Caseworker that Medicaid is ready to be approved, if the child is approved for level of care and the initial Plan of Care is approved, the CMHC staff or Wraparound Facilitator generates the final, formal *Notice of Action, HCBS Form 5* and submits a copy to the CEU Caseworker.
7. The CEU Caseworker will authorize Medicaid and will notify the CMHC staff.
8. The CEU transfers the case to the local OFC in the county where the individual resides and will provide the contact information of the local OFC Caseworker and the Caseworker Supervisor to the Wraparound Facilitator.

If the child is not a Medicaid recipient at the time of the waiver application, but is eligible without the parental income and resource disregard, Medicaid eligibility may be retroactive to 3 months prior to the month of application.

5.4 Institutional Deeming Rules

Under usual circumstances, when a child remains in the community, parental income and resources must be considered in determining a child's financial need for Medicaid; however, parental income and resources are disregarded in determining a child's financial need for Medicaid if the child is being admitted to an institution such as a mental health hospital.

Parental income and resources are also disregarded under a Medicaid Home and Community-Based Waiver. Some children will not be eligible for Medicaid until they are determined to be eligible for the SED Waiver. **The CMHC/Wraparound Facilitator must report to DMHA if a child is eligible for Medicaid due to parental income and resources disregard.**

The exclusion of parental resources and income applies only as long as the child is approved for a Medicaid Home and Community-Based Waiver. Parental deeming resumes beginning the month following the month in which the SED Waiver is discontinued. **When waiver eligibility is discontinued, the Wraparound Facilitator must send a copy of the *Notice of Action* to the local Office of Family and Children (OFC) indicating that the child is no longer eligible for the SED Waiver.**

Although parental income and resources are disregarded, the child's income and resources are utilized to determine financial eligibility for Medicaid.

5.5 Office of Medicaid Policy and Planning Level of Care Determination

The Level of Care packet including the *Mental Health Hospital Level of Care Application;* the *Transmittal for Medicaid Level of Care Eligibility* if LOC application is not submitted through INsite; the *Long Term Care Application, the Freedom of Choice* form, and the *Provisional Plan of Care* (see Section 6.1.2) signed by the recipient/guardian and the CMHC designee or Wraparound Facilitator are submitted to the DMHA Waiver Manager. The DMHA Waiver Manager will forward the Level of Care packet to the Office of Medicaid Policy and Planning for approval. The Level of Care application may be submitted to the Office of Medicaid Policy and Planning (OMPP) directly through INsite. DMHA and/or the Office of Medicaid Policy and Planning may request additional information from the CMHC, Wraparound Facilitator, individual, family, or service providers

5.5.1 Level of Care Approved - Slot Available

If a waiver slot is available, the child is a Medicaid recipient and the level of care recommendation is approved by OMPP, the DMHA Waiver Manager will notify the CMHC designee or the Wraparound Facilitator and will take action on the Provisional Plan of Care.

5.5.2 Level of Care Approved - No Waiver Slot Available

If the applicant is approved for mental health hospital level of care by the Office of Medicaid Policy and Planning but there is a waiting list for the SED Waiver, the CMHC must provide the child/parent/guardian with a *Notice of Action,* indicating that waiver services have been denied due to the unavailability of a waiver slot. The Division of Mental Health and Addiction and/or the Office of Medicaid Policy and Planning may request additional information from the CMHC, Wraparound Facilitator, individual, family, or service providers.

DMHA will maintain waiting lists for each System of Care area. Individuals from the waiting lists will be targeted on a first-come, first-serve basis within their area. DMHA may redistribute slots based on local need.

If the Level of Care assessment is denied for a child who has been on the waiting list, the child's name should be removed from the waiting list; however, the child's name should not be removed for 30 days to allow opportunity for the applicant/guardian to appeal the denial. If the applicant/guardian appeals the denial decision, the child's name should not be removed from the waiting list until the fair hearing results in the denial decision being upheld, or the applicant/guardian withdraws the request for a fair hearing (at which time the next child on the list may be targeted). After 30 days with no appeal of the denial, the next child on the waiting list may be targeted.

5.5.3 Level of Care Not Approved

If the Office of Medicaid Policy and Planning determines that the applicant does not meet mental health hospital level of care, and is therefore, ineligible for services under the SED Waiver, the CMHC completes a *Data Entry Worksheet* indicating that services have been denied and the *Notice of Action* must be sent to the applicant/family. DMHA and/or OMPP may request additional information from the CMHC, the individual, family, or service providers.

If the Level of Care assessment is denied, a waiver slot must be held to allow the child or guardian to appeal the denial. If the applicant/guardian appeals the denial decision, the slot must be held open until the fair hearing results in the denial decision being upheld, or the applicant/guardian withdraws the request for a fair hearing (at which time the next child may be targeted). After 30 days with no appeal of the denial, the next child may be targeted.

5.6 Annual Level of Care Reassessment

All children receiving services under the SED Medicaid Home and Community-Based Waiver must be re-evaluated annually to substantiate their continuing need for the level of care provided in a mental health hospital. The point at which the child no longer meets this level of care, he/she is no longer eligible for Medicaid SED waiver services. If the child's condition changes significantly, the level of care reassessment may be completed prior to the annual due date.

The level of care reassessment is completed by the CMHC staff qualified to do so during the same month of the year in which the initial level of care determination was made. (These annual reassessments must be completed by a Qualified Mental Health Professional as defined in 405 IAC 5-21-1.) In addition to a new *Level of Care Application*, a *Statement of Freedom of Choice* form must also be completed and signed by the recipient/guardian and the CMHC designee or Wraparound Facilitator. Copies are forwarded to the DMHA Waiver Manager who forwards the Level of Care packet to the Office of Medicaid Policy and Planning (OMPP) or it may be submitted to OMPP directly through INsite.

If, as a result of the CMHC level of care reassessment, it is determined by the Office of Medicaid Policy and Planning (OMPP) that the applicant no longer meets hospital level of care, and is therefore, ineligible for continuing services under the SED Waiver, the CMHC completes a *Data Entry Worksheet* indicating that the individual is no longer eligible and sends a *Notice of Action* to the child/family and the local Office of Family and Children (OFC).

If the individual/guardian appeals the discontinuance prior to the effective date of the action, waiver services should continue pending receipt of a decision in the appeal. If the applicant guardian does not appeal prior to the date of the action, a

slot should be held for 30 days to allow time for the applicant/guardian to appeal. A slot must be held open until the fair hearing results in the denial decision being upheld, or the applicant/guardian withdraws the request for a fair hearing (at which time the next child may be targeted). After 30 days with no appeal of the denial, the next child may be targeted.

DMHA and OMPP may request additional information from the CMHC, Wraparound Facilitator, individual, family, or service providers.

5.7 Level of Care Circumstances Requiring a Notice of Action

A *Notice of Action* form must be generated under the following circumstances:

1. The individual is determined to meet the level of care for the waiver by OMPP, but there are no slots available. A *Notice of Action* indicating a denial should be sent to the child/guardian.

2. OMPP determines (or concurs) that the individual does not meet level of care and is therefore, not eligible. A *Notice of Action* indicating a denial should be sent to the child/guardian.

3. The individual was eligible but no longer meets level of care. A *Notice of Action* indicating a termination should be sent to the child/guardian.

A Notice of Action is <u>never</u> generated at the point the child is determined to meet the Institutional Level of Care and targeted for a slot. In this case, the Notice of Action indicating eligibility will be generated at the time the first Plan of Care is approved.

Section 6. Plan of Care/Cost Comparison Budget (POC/CCB)

(Definition, Development, Authorization, and Implementation)

No waiver services, including Wraparound Facilitation will be reimbursed earlier than the latest of the following dates:

- Medicaid eligibility date;
- Level of care approval date;
- Date upon which applicant who is on a Medicaid Managed Care is transferred from Medicaid Managed Care (Hoosier Healthwise, Medicaid Select);
- Waiver slot availability date;
- Hospital discharge date if applicable;
- Plan of Care developed/signed/implemented.

There are 4 types of Plans of Care/Cost Comparison Budgets: Provisional; Comprehensive; Update; and Quarterly. A Provisional Plan of Care will be the initial Plan of Care. When all six criteria above have been met, waiver services on the Provisional Plan of Care are reimbursable by Medicaid.

6.1 Provisional Plan of Care

6.1.1 Provisional Plan of Care Definition

A provisional Plan of Care facilitates expeditious initiation of waiver services by identifying the essential Medicaid services that will be provided in the first 60 days of waiver eligibility. **Wraparound Facilitation is the service through which a comprehensive plan is designed and is the only SED Waiver service identified on the Provisional Plan of Care,** although other Medicaid/non-Medicaid services must be identified.

The Comprehensive Plan of Care must be developed to replace the Provisional Plan of Care within 60 days of the Provisional Plan's effective date, or waiver services will not be reimbursable by Medicaid beyond the first 60 days.

6.1.2. Provisional Plan of Care/Cost Comparison Budget Development

The Provisional Plan of Care is completed by the CMHC staff person who is responsible for the level of care assessment. Wraparound Facilitation will not be reimbursable until the DMHA Waiver Manager approves the Plan of Care and all six criteria above have been met.

- The Provisional Plan of Care must identify "Wraparound Facilitation" services which are necessary to facilitate the development of the Comprehensive Plan of Care/Cost Comparison Budget. Other estimated costs to Medicaid should be included on the Provisional Plan of Care, including:
  - clinic option;
  - MRO; and
  - Other Medicaid acute care and long term care costs.

The Division of Mental Health and Addiction will monitor average per capita costs programmatically. Therefore, if a child's cost to Medicaid for community based services exceeds an average of $40/day, the Wraparound Facilitator must explain the reason for the high cost and ask for an approval to exceed an average of $40/day. The following issues should be addressed:

1. How the individual's needs drive the budget; and
2. The specific steps being taken, including timeframes, to reduce the individual's behavioral, medical or other issues causing the need for high levels of service.

The recipient/parent/guardian must sign the Provisional Plan of Care indicating acceptance and the CMHC staff or the Wraparound Facilitator must inform the recipient/parent/guardian that he/she has the right to choice of certified waiver providers.

6.1.3 State Authorization of the Provisional Plan of Care

Upon receiving the Provisional Plan of Care from the CMHC, the DMHA Waiver Manager will review the Plan of Care and confirm the following:

1. The child is a current Medicaid recipient;
2. The child has a current hospital level of care approval;
3. The child has been targeted for an available waiver slot;
4. The child, parent, or guardian has signed indicating acceptance of the Plan of Care;
5. The child has been transferred from Medicaid Managed Care;
6. The recipient, parent, or guardian has been offered choice of certified providers and has chosen waiver services over services in a hospital
7. If the child is in an institutional setting, the Provisional Plan of Care may be approved pending discharge from the institution.

The DMHA Waiver Manager may request additional information from the CMHC to assist in reviewing the Plan of Care. The DMHA Waiver Manager will inform the CMHC designee or Wraparound Facilitator of the approval; approval pending certain criteria being met; or denial of the Provisional Plan of Care. The DMHA Waiver Manager may approve the plan, pending the confirmation of the

above conditions. If/when all of the above conditions are met, the Wraparound Facilitator must "confirm" that the child is ready to start services.

When the DMHA Waiver Manager approves the Provisional Plan of Care, a *Notice of Action*, is generated by INsite, (containing information from the Provisional Plan of Care) and should be sent to the individual/guardian, the DMHA Waiver Manager, and the Wraparound Facilitation Service provider.

An update may be done to the Provisional Plan of Care at any time during the 60-day life of the Plan to add services after a strengths/needs assessment and the child/family team meeting.

6.1.4 Provisional Plan of Care Implementation

Waiver services outlined on the Provisional Plan of Care may begin at the time of approval by the DMHA Waiver Manager. Services on the Provisional Plan of Care may be retroactive to the date the Plan of Care was signed if approved by the DMHA Waiver Manager.

Within 14 calendar days after the individual begins waiver services, the Wraparound Facilitator must confirm that the Plan of Care has been implemented.

6.1.5 Provisional Plan of Care - Pending Issues Implementation

If the DMHA Waiver Manager approves a Plan of Care pending certain conditions being met; those conditions must be resolved prior to the start of the waiver services.

If the child's Medicaid eligibility depends on waiver approval, the CMHC staff or Wraparound Facilitator coordinates the Medicaid eligibility date and waiver start date with the DFC CEU.

When the Provisional Plan of Care/Cost Comparison Budget is approved by the DMHA Waiver Manager pending hospital discharge, the waiver start date can be the same day that the individual is discharged from the hospital. The Provisional Plan of Care will be effective to the end date of the original that was previously approved pending certain conditions by the DMHA Waiver Manager. For example, the Plan of Care/Cost Comparison Budget is signed by the child/parent/guardian on April 1, 2004, and approved by the DMHA Waiver Manager on April 6, 2004, pending the child's move from a state hospital. The child moves out of the hospital to the community on May 1, 2004. The Plan of Care/Cost Comparison Budget is effective through June 30, 2004 (rather than July 31, 2004).

Services will not be reimbursed prior to a child's disenrollment from a Medicaid managed care program. If an individual is a Hoosier Healthwise or other Medicaid managed care program participant, the Wraparound Facilitator must

contact the local Office of Family and Children (OFC) Caseworker to coordinate the managed care program stop date and waiver start date. The Wraparound Facilitator and Managed Care Benefit Advocate must inform the individual's parent/guardian of his/her options to assure he/she makes an informed choice. See www.indianamedicaid.com/ihcp/HoosierHealthwise/content/links.asp

Within 14 calendar days after all pending issues are resolved and the individual begins waiver services, the Wraparound Facilitator must confirm the actual start date.

6.2 Comprehensive Plan of Care/Cost Comparison Budget

6.2.1 Comprehensive Plan of Care/Cost Comparison Budget Definition

A Comprehensive Plan of Care must be developed and approved within 60 days of the effective date of the Provisional Plan of Care. The Comprehensive Plan of Care includes waiver services, other Medicaid services and their costs, services funded through other sources, informal support services, goals, outcomes and a crisis plan.

6.2.2 Comprehensive Plan of Care Development

The Comprehensive Plan of Care must include the child's strengths and needs, presenting problem, goals/outcomes, potential crises and crisis plan, as well as the services and supports necessary to assure health, safety, and Plan of Care objectives, including waiver services, MRO services, other Medicaid services, services funded through other sources, and informal support services.

Utilizing the core values and guiding principles for a *System of Care*, the Wraparound Facilitator is responsible for facilitating the development of a Plan of Care. A System of Care is defined as a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families.

Core Values specify that services should be
- Community based;
- Child centered;
- Family focused; and
- Culturally/linguistically competent.

Guiding Principles specify that services should be:
- Comprehensive, incorporating a broad array of services and supports;
- Individualized;
- Provided in the least restrictive, appropriate setting;
- Coordinated both at the system and service delivery levels;
- Involve families and youth as full partners; and

- Emphasize early identification and intervention.*

6.2.3 Comprehensive Cost Comparison Budget Development

The Wraparound Facilitator must determine the estimated average monthly costs of all services reimbursed by Medicaid:

- waiver services;
- clinic option;
- MRO; and
- Other Medicaid acute care and long term care costs.

The Division of Mental Health and Addiction will monitor average per capita costs programmatically. Therefore, if a child's cost to Medicaid for community based services exceeds an average of $40/day, the Wraparound Facilitator must explain the reason for the high cost and ask for an approval to exceed an average of $40/day. The following issues should be addressed:

1. How the individual's needs drive the budget; and
2. The specific steps being taken, including timeframes, to reduce the individual's behavioral, medical or other issues causing the need for high levels of service.

The recipient/parent/guardian must sign the Plan of Care/Cost Comparison Budget indicating acceptance and the Wraparound Facilitator must inform the recipient/parent/guardian that he/she has the right to choose any certified waiver provider.

6.2.4 State Authorization of the Comprehensive Plan of Care and Cost Comparison Budget

Within five (5) business days of receipt of a Comprehensive Plan of Care from the Wraparound Facilitator, the Waiver Manager will review the Plan of Care/Cost Comparison Budget and confirm the following:

1. The child is a current Medicaid recipient;
2. The child has a current hospital level of care approval;
3. The child has been targeted for an available waiver slot;
4. The individual's identified needs have been addressed assuring health and safety and costs are consistent with needs;
5. Programmatic cost-neutrality will be maintained;
6. The recipient, parent, or guardian has signed indicating acceptance of the Plan of Care/Cost Comparison Budget;
7. The recipient, parent, or guardian has signed that he/she has been offered choice of certified providers and has chosen waiver services over services in a hospital.

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* Building Systems of Care A Primer, Sheila A. Pires, Human Service Collaborative, Washington DC, Spring 2002.

The Waiver Manager may request additional information from the Wraparound Facilitator to assist in reviewing the Plan of Care. The Comprehensive Plan of Care will be approved, denied, or additional information may be requested from the Wraparound Facilitator.

If denied the Wraparound Facilitator will send a *Notice of Action* to the child/parent/guardian with an explanation of the reason for denial and will discuss other service options with the child/parent/guardian. A waiver slot must be reserved for the child pending the possibility of an appeal. Appeals are to be filed not later than thirty (30) days following the effective date of the action, or thirty (30) days following the date the notice of the decision was mailed (whichever is later).

If the Waiver Manager approves the Plan of Care/Cost Comparison Budget, the Wraparound Facilitator will send a *Notice of Action* (containing information from the Plan of Care/Cost Comparison Budget) to the individual/guardian, the DMHA Waiver Manager, and to all of the individual's waiver service providers.

6.2.5 Comprehensive Plan of Care Implementation

Waiver services outlined on the Comprehensive Plan of Care may begin at the time of approval by the DMHA Waiver Manager.

6.3 Update/Quarterly Plan of Care/Cost Comparison Budget

6.3.1 Update Plan of Care/Cost Comparison Budget Definition

A Plan of Care/Cost Comparison Budget is revised/updated when the type of service(s) needed by the child changes and/or the amount of services needed by the child increases or decreases.

6.3.2 Quarterly Plan of Care/Cost Comparison Budget Definition

Children receiving SED Waiver services must have a new Plan of Care/Cost Comparison Budget approved every 3 months. Quarterly Plans of Care/Cost Comparison Budgets are to start on the day following the day that the existing Plan of Care/Cost Comparison Budget expires, and cover a 3-month period.

6.3.3 Update and Quarterly Plan of Care/Cost Comparison Budget Development

Plans of Care/Cost Comparison Budgets may be updated at any time. Quarterly Plans of Care/Cost Comparison Budgets must be developed and signed prior to the expiration date of the current Plan of Care/Cost Comparison Budget. The Wraparound Facilitator is **not** required to submit the update or quarterly Plan of Care/Cost Comparison Budget to the DMHA Waiver Manager for approval unless the cost of the budget to Medicaid exceeds $3,600 in a quarter. If changes in an updated or quarterly Plan of Care/Cost Comparison Budget result in cost greater than $3,600 per quarter, or if the Plan of Care/Cost Comparison Budget continues in excess of $3,600 per quarter, the Plan of Care/Cost Comparison Budget must be forwarded to the DMHA Waiver Manager for approval. The DMHA Waiver Manager must receive the "high cost" Quarterly Plans of Care at least 1 week prior to the current Plan of Care/Cost Comparison Budget expiration.

If the child's cost to Medicaid for community based services exceeds $3,600 per quarter, the Wraparound Facilitator must explain the reason for the high cost and ask for an approval to exceed the institutional costs. The following issues should be addressed:

1. How the individual's needs drive the budget; and
2. The specific steps being taken, including timeframes, to reduce the individual's behavioral, medical or other issues causing the need for high levels of service.

The child/guardian must sign the new Plan of Care/Cost Comparison Budget indicating acceptance and the Wraparound Facilitator must inform the child/parent/guardian that he/she has the right to choose any certified waiver provider including the Wraparound Facilitator.

The signed Plan of Care/Cost Comparison Budget is forwarded to the DMHA Waiver Manager.

6.3.4 State Authorization of the Update/Quarterly Plan of Care/Cost Comparison Budget

Within 5 business days of receiving an update or quarterly Plan of Care/Cost Comparison Budget that exceeds the recommended cost limit, the DMHA Waiver Manager will review the Plan of Care/Cost Comparison Budget and confirm that:

1. The child is a current Medicaid recipient;
2. The child has a current hospital level of care approval;
3. The child has been targeted for an available waiver slot;
4. The individual's identified needs have been addressed assuring health and safety and costs are consistent with needs;
5. Programmatic cost-neutrality will be maintained;
6. The recipient, parent, or guardian has signed indicating acceptance of the Plan of Care/Cost Comparison Budget;

7. The recipient, parent, or guardian has signed that he/she has been offered choice of certified providers and has chosen waiver services over services in a hospital.

The DMHA Waiver Manager may request additional information from the Wraparound Facilitator to assist in reviewing the Plan of Care/Cost Comparison Budget.

If the DMHA Waiver Manager denies the Plan of Care/Cost Comparison Budget, the Wraparound Facilitator will send a denial *Notice of Action* to the child/parent/guardian. A copy of the *Notice of Action* is sent to the local Office of Family and Children. The Wraparound Facilitator will discuss other service options with the child/parent/guardian and the child's waiver services should be discontinued unless the child/guardian appeals the action prior to the effective date of the action. (See Section 8.)

If the Waiver Manager approves the Update Plan of Care/Cost Comparison Budget, the Wraparound Facilitator must send the *Notice of Action*, (containing information from the Plan of Care/Cost Comparison Budget) to the individual/guardian and to all of the individual's waiver service providers.

6.3.5 Update or Quarterly Plan of Care Implementation

Waiver services outlined on the Update may begin the date the proposed change is approved by the DMHA Waiver Manager. Services on the Quarterly Plan of Care begin on the effective date, which is the date the previous Plan of Care expires.

6.4 Spenddown

Federal rules require Indiana (and other 209(b) states) to allow Medicaid recipients with too much income for SSI who are elderly, blind, or have disabilities, to spend down to the State's Medicaid income standard if their expenses for medical and remedial services so erode their income that their "net" remaining income would be less than the standard set by the state.[*]

Spend-down is similar to an insurance deductible. Medicaid recipients must incur medical expenses (spenddown) in the amount of their excess income each month before their remaining medical expenses are eligible for Medicaid reimbursement. For these recipients, the provider collects payment for the service from the member, or bills the member if payment is not collected on the date of service. Then incurred charges are reported to the local OFC.

[*] Understanding Medicaid Home and Community Services: A Primer, U.S. Department of Health and Human Services, October 2000.

If the date of service is prior to the date spenddown was met, the service is not reimbursable by Medicaid.

6.5 Termination of Waiver Services

Waiver services will be terminated when:

- The child reaches age 22;
- The child or parent/guardian chooses institutional placement;
- The child needs services so substantial that the total cost of Medicaid services for the child would jeopardize the waiver program's cost-neutrality;
- The child no longer meets the level of care for a psychiatric hospital;
- The child becomes eligible for a residential level of care;
- The child is no longer eligible for Medicaid;
- The child no longer requires waiver services;
- The child is no longer a resident of an Indiana participating waiver county;
- The child dies.

The Wraparound Facilitator discusses termination with the individual/ parent/guardian and provides them a *Notice of Action* noting the effective date of and reason for the termination. A copy of the *Notice of Action* should be forwarded to the service providers, the DMHA Waiver Manager and the local Office of Family and Children.

The child or parent/ guardian may appeal the termination no more than 30 days following the effective date of the termination or 30 days following the date the notice of termination was mailed (whichever is later). If the appellant has requested a hearing prior to the effective date of the proposed action, he/she is entitled to continue benefits. In this case, benefits are not allowed to be reduced or terminated prior to receipt of the official hearing decision. (See Section 8, Appeal Track for Medicaid Actions.)

6.6 Waiver Slot Retention and Re-entry after Termination

If a child has been terminated from the SED Waiver and wishes to return to the program, he/she may do so within the same waiver year of his/her termination, if otherwise eligible. The child shall be allowed to return to waiver programming without going on a waiting list. The SED Waiver year is February 1 through January 31. If a child leaves the waiver in April and is eligible and wishes to return in October, he/she may do so if waiver requirements are still met. If he/she leaves the waiver in April and wishes to return the following February, he/she may be placed on a waiting list if there are no slots available.

A child who has been terminated from the waiver program within 30 calendar days, may resume waiver programming with the same level of care approval date and Plan of Care/Cost Comparison Budget if the child's condition has not

significantly changed and the Plan of Care/Cost Comparison Budget continues to meet his/her needs and the child is otherwise eligible. A copy of the latest Plan of Care/Cost Comparison Budget should be forwarded to the DMHA Waiver Manager with the word "resumption" at the top.

If a child has who has been terminated from the waiver program longer than 30 calendar days, yet within the waiver year, wishes to return to the program and is otherwise eligible, the Wraparound Facilitator is responsible for developing the level of care packet and the Plan of Care/Cost Comparison Budget following the same processes described in the Initial Level of Care Assessment and the Comprehensive Plan of Care/Cost Comparison Budget Development and Implementation sections (Sections 5.1, 5.2, 6.1, 6.2).

The Wraparound Facilitator indicates a "Re-entry" Plan of Care/Cost Comparison Budget and submits to the DMHA Waiver Manager. If approved a *Notice of Action* (containing information from the Plan of Care/Cost Comparison Budget) is sent by the Wraparound Facilitator to the individual/guardian and to all of the individual's waiver service providers. Within 14 calendar days after the individual begins waiver services, the Wraparound Facilitator must notify the DMHA Waiver Manager that the Plan of Care has been implemented by confirming it in INsite.

When a child "re-enters" waiver services:

- If within 30 days of terminating Waiver services, the level of care and quarterly Plan of Care/Cost Comparison Budget dates remain the same dates as they were prior to the termination of Waiver services,
- If more than 30 days since terminating Waiver services, the new level of care and Plan of Care/Cost Comparison Budget dates are used for determining when future annual level of care determinations and quarterly Plans of Care/Cost Comparison Budgets are due.

6.7 Transfer of Information between Wraparound Facilitators

Individuals/parents/guardians may choose a new Wraparound Facilitator at any time. It is the responsibility of both Wraparound Facilitators to work cooperatively with the child and his/her family to determine a transition date and assure a smooth transition.

The new Wraparound Facilitator explains his/her need with the child or parent/guardian to obtain a copy of the previous Wraparound Facilitator's records and files concerning the child, requests the child or parent/guardian sign a release form for the records, and forwards the release form to the previous Wraparound Facilitator. Upon receipt of the signed release, the previous Wraparound Facilitator forwards a copy of all the individual's records no later than 7 days after the receipt of the signed release.

6.8 Plan of Care Circumstances Requiring a Notice of Action

1. The DMHA Waiver Manager denies the Plan of Care or Cost Comparison Budget. Wraparound Facilitator sends *Notice of Action* to child/guardian, DMHA Waiver Manager, to the local OFC.
2. The DMHA Waiver Manager approves the Plan of Care and Cost Comparison Budget. Wraparound Facilitator sends *Notice of Action* to child/guardian, DMHA Waiver Manager, OFC, and all of child's waiver providers.
3. The DMHA Waiver Manager approves the Plan of Care/Cost Comparison Budget pending certain conditions being met. After conditions are met, Wraparound Facilitator sends Notice of Action to child/guardian, DMHA Waiver Manager, DFC Central Enrollment Unit, the local OFC, and all waiver service providers.
4. When services on the Plan of Care/Cost Comparison Budget are changed, increased and/or decreased. The Wraparound Facilitator sends a Notice of Action to the child/guardian, the DMHA Waiver Manager, and all waiver service providers.
5. Child resumes or re-enters waiver program. A *Notice of Action* is sent to the individual/guardian and the DMHA Case Manager, the local OFC and all waiver service providers.

Section 7. Level of Care Codes, Service Procedure Codes and Rates

7.1 Level of Care Codes

The Indiana Division of Mental Health and Addiction have identified 16 Level of Care codes to be utilized to identify the state agency responsible for providing the state's share of Medicaid costs as well as to identify whether a child is being diverted from hospital placement, or is being transitioned from the hospital back to the community.

SED Waiver Level of Care Codes

LOC Code		Definition			
E00		SED Waiver	Diverted	DMHA funded	Effective 02-01-2004
E01		SED Waiver	Diverted	SEA-30 DMHA funded	Effective 02-01-2004
E10		SED Waiver	Diverted	DOC funded	Effective 02-01-2004
E11		SED Waiver	Diverted	SEA-30 DOC funded	Effective 02-01-2004
E20		SED Waiver	Diverted	DOE funded	Effective 02-01-2004
E21		SED Waiver	Diverted	SEA-30 DOE funded	Effective 02-01-2004
E30		SED Waiver	Diverted	DFC funded	Effective 02-01-2004
E31		SED Waiver	Diverted	SEA-30 DFC funded	Effective 02-01-2004
E50		SED Waiver	Community Transition	DMHA funded	Effective 02-01-2004
E51		SED Waiver	Community Transition	SEA-30 DMHA funded	Effective 02-01-2004
E60		SED Waiver	Community Transition	DOC funded	Effective 02-01-2004
E61		SED Waiver	Community Transition	SEA-30 DOC funded	Effective 02-01-2004
E70		SED Waiver	Community Transition	DOE funded	Effective 02-01-2004
E71		SED Waiver	Community Transition	SEA-30 DOE funded	Effective 02-01-2004
E80		SED Waiver	Community Transition	DFC funded	Effective 02-01-2004
E81		SED Waiver	Community Transition	SEA-30 DFC funded	Effective 02-01-2004

7.2 Procedure Codes and Rates

The administrative simplification provision of the Health Insurance Portability and Accountability Act (HIPAA) requires the U.S. Department of Health and Human Services to adopt national standards for electronic health care transactions. Service procedures codes for he SED Waiver are compliant with HIPAA, and HIPAA service designations have been assigned to the specific SED Waiver services. For example, there is no national code for "Wraparound Facilitation". Therefore, the service designated by HHS that is defined similarly to Wraparound Facilitation is "Case Management each". Providers utilize the procedure code for "Case Management each" and designate the service as "Case Management each" rather than "Wraparound Facilitation" for billing purposes only.

When billing for services, waiver providers must utilize not only appropriate procedure and waiver codes, but the appropriate HIPAA service designations as well. One hour of Wraparound Facilitation will be billed as code T1016 U7, described as Case Management each, 4 units @ $28.75.

SED Waiver Procedure Codes (HIPAA Codes)

SED WAIVER PROCEDURE CODES (HIPAA CODES)

SED Waiver Service	HIPAA CODE	Waiver Code	Waiver Service	HIPAA Service Definition	Unit	Unit Rate
Wraparound Facilitation	T1016	U7	Wraparound Facilitation	Case Management each	15 minutes	$28.75
Family Support and Training	T1027	U7	Family Support and Training	Family training and counseling for child development	15 minutes	$15.00
Independent Living Skills	T2013	U7	Independent Living Skills	Habilitation, educational, waiver	hour	$85.60
Respite Care Scheduled Hourly	S5150	U7	Respite Scheduled Hour	Unskilled respite care, not hospice	15 minutes	$4.00
Respite Foster Care Hourly	S5150	U1, U7	Respite Foster Care Hour	Unskilled respite care, not hospice	15 minutes	$5.00
Respite Care Crisis Hourly	S5150	U2, U7	Respite Crisis Hour	Unskilled respite care, not hospice	15 minutes	$6.00
Respite Care Scheduled Day	S5151	U7	Respite Scheduled Day	Unskilled respite care, not hospice	per diem	$80.00
Respite Foster Care Day	S5151	U1, U7	Respite Foster Care Day	Unskilled respite care, not hospice	per diem	$100.00
Respite Care Crisis Day	S5151	U2, U7	Respite Crisis Day	Unskilled respite care, not hospice	per diem	$120.00

Section 8. Appeals and Hearings

An appeal is a request for a hearing before an Administrative Law Judge with the Family and Social Services Administration, Hearings and Appeals Section. The purpose of an appeal is to determine whether a decision made by a Wraparound Facilitator, the Division of Mental Health and Addiction, or the Office of Medicaid Policy and Planning Level of Care Unit, affecting the recipient/consumer, is correct. An appeal request must be in writing and forwarded to the hearing authority.

8.1 Assistance in Exercising the Right to Appeal

Any applicant for services or any individual receiving services via the SED Waiver who is dissatisfied with an action may request a fair hearing. Any time an individual/parent/guardian expresses a disagreement with any action taken, he/she must be verbally reminded of the right to request a fair hearing. Assistance is to be provided to the individual/parent/guardian who is having difficulty in preparing the written request for an appeal.

The individual/parent/guardian is to be informed that he/she may represent himself/herself at the hearing or be represented by an attorney, a relative, a friend, or any other spokesman of his/her choice. Information and referral services should also be provided to help the dissatisfied individual/parent/guardian make use of any free legal services that are available in the community.

8.2 Written Request for Appeal

An individual (or representative) must make an appeal request in writing. The written appeal request must be submitted to the Family and Social Services Administration, Hearings and Appeals Section, 402 W. Washington Street, Room 392, Mail Stop 04, Indianapolis, Indiana 46204. This appeal request will also be faxed to the Hearings and Appeals Section at (317) 232-4412.

8.3 Appealable Actions

Under 405 IAC 1.1-1 et seq. appealable actions are issues relating to the waiting list; no waiver slots being available; application not being acted upon with reasonable promptness, initial, annual, and periodic level of care determinations; both initial and quarterly plans of care including service plans and cost comparison budgets; termination of waiver services; re-entry into the waiver after termination; and waiver transfers.

8.4 Time Limits for Requesting Appeals

Appeals are to be filed not later than thirty (30) days following the effective date of the action, or thirty (30) days following the date the notice of the decision was mailed (whichever is later).

8.5 Continuation of Benefits

The appellant is entitled to continue benefits after requesting a hearing only if the request is received prior to the effective date of the proposed action.

Once continued benefits are allowed, benefits are not to be reduced or terminated prior to receipt of the official hearing decision. If a new action is proposed for a different time period and the recipient does not request an appeal, the new action can take place even if the pervious appeal is still continuing.

8.6 The Hearing Notice

The Family and Social Services Administration, Hearings and Appeals Section, sends a notice acknowledging the appeal. The notice is sent to all parties, which includes the individual (the representative), and the Wraparound Facilitator. The Office of Medicaid Policy and Planning Level of Care Unit would also be included in receiving a notice if they were involved in making the decision.

8.7 Review of Action

When an appeal request is received, the Wraparound Facilitator or the Office of Medicaid Policy and Planning Level of Care Unit should review the proposed action to determine whether the proposed action is appropriate.

The Wraparound Facilitator or the Office of Medicaid Policy and Planning Level of Care Unit (or representative) must offer the individual (or representative) the possibility of an informal conference and an opportunity to review the evidence prior to the hearing. Individuals/parents/guardians should be advised that an informal conference prior to the hearing is optional and in no way delays or replaces the administrative hearing. The conference may lead to an informal resolution of the dispute. An administrative hearing must still be held unless the child or parent/guardian withdraws the request for a hearing in writing.

If, after review of the appellant's situation, the Wraparound Facilitator or the Office of Medicaid Policy and Planning Level of Care Unit realizes that the proposed action or action taken is incorrect, then adjusting action may be taken. The appellant and the Hearings and Appeals Section are to be promptly notified in writing that the incorrect action is being withdrawn or rescinded.

If the appellant wishes to withdraw the appeal, he/she is to be assisted by the Wraparound Facilitator or the Office of Medicaid Policy and Planning Level of Care Unit in promptly notifying the Hearings and Appeals Section in writing of the decision. No pressure is to be exerted on the appellant to withdraw the appeal. The withdrawal will be acknowledged in writing. The appeal is then dismissed.

When the withdrawal of an appeal request is not submitted in writing, the Hearings and Appeals Section will notify the parties that the appeal will be

dismissed unless notification is received promptly that the appellant did not, in fact, withdraw the appeal request.

An appeal is abandoned when the appellant (or representative) without good cause, does not appear at a scheduled hearing. The appeal will be dismissed and the parties so notified.

8.8 Preparation for Hearing by Appellant

As the appellant prepares for the hearing, the appellant (or representative) is to be given an opportunity to:

- Discuss the issue being appealed with the Wraparound Facilitator the Office of Medicaid Policy and Planning Level of Care Unit (or representative).
- Examine the entire case file and all documents and records that will be used by the Wraparound Facilitator or the Office of Medicaid Policy and Planning Level of Care Unit at the hearing.
- Obtain free of charge copies of all exhibits that will be used as evidence by the Wraparound Facilitator or the Office of Medicaid Policy and Planning Level of Care Unit at the hearing.

The appellant is to be advised of any legal services available to provide representation at the hearing.

8.9 Preparation for Hearing by the Wraparound Facilitator or the Office of Medicaid Policy and Planning Level of Care Unit

The correct application of federal or state law or regulation to the appellant's situation should be reviewed by the Wraparound Facilitator or the Office of Medicaid Policy and Planning Level of Care Unit prior to the hearing. Thorough support of the action proposed or taken must be provided at the hearing.

The person testifying should be the person with the most direct contact with the action being proposed or taken. In the absence of the person with the most knowledge of the hearing situation, a person familiar with the action and the case record should substitute.

To prepare for the hearing, the Wraparound Facilitator or the Office of Medicaid Policy and Planning Level of Care Unit is to:

- Review all factors and issues that led to the action being appealed;
- Discuss the issue being appealed with the appellant (or representative) if at all possible, and definitely if a discussion is requested by the appellant. If requested, allow the appellant (or representative) to examine the entire case record;

- Identify and label all documents that are pertinent to the issue under appeal. The exhibits should be labeled in the lower right hand corner with the State's Exhibit being Exhibit A. If more than one page is in an exhibit, the pages are labeled (for the first page) State's Exhibit A, page 1 of 2; and (for page 2) State's Exhibit A, page 2 or 2. The next numbers continue for each page in the exhibit being presented. The subsequent exhibit would be labeled Exhibit B and the pages according to the number of pages. Example [If three pages are in an exhibit, the third page would be labeled]:

  State's Exhibit A
  Page 3 of 3

- Make one copy of labeled exhibits for the Administrative Law Judge and one copy for the appellant (unless already given to the appellant). A duplicate copy of the notice sent to the appellant advising of the proposed action should be included as part of the documentation;
- Prepare a written outline that can be used as a tool in presenting the testimony at the hearing. Bear in mind when preparing the outline that the Administrative Law Judge knows nothing about the situation. The outline should focus on:
  - identification of the staff representative by name and position;
  - the period of time the representative worked directly or indirectly with the appellant;
  - one sentence explanation of the issue under appeal;
  - the important information concerning how it was determined that the action proposed or taken was appropriate; and
  - Federal and state laws and regulations that were the basis for the action.
- Include the labeled exhibits at the appropriate point in the presentation outline.

8.10 The Hearing Order

The Administrative Law Judge will make a non-final written Order based upon relevant Indiana Code and the evidence of record in the proceeding and will have copies of the Order delivered to each party and to the Director of the Division of Mental Health and Addiction Services. The findings of fact will be accompanied by a concise statement of the underlying facts of the record to support the findings as well as a statement regarding the process for further appeal of the Order and the time frame for seeking Administrative Review of the Order. The findings will be sent to all parties and the Deputy Director of the Division of Mental Health and Addiction Services within 90 days of the conclusion of the hearing or after the submission of the proposed findings. The time period may be waived or extended with the written consent of all parties or for good cause shown.

8.11 Objection to Non-Final Order

If the appellant is dissatisfied with the non-final Order issued by the Administrative Law Judge, the appellant may appeal to the Director of the Division of Mental Health and Addiction Services in writing within 15 days of the non-final Order.

If the appellant is dissatisfied with the non-final Order, an objection may be filed in writing to the Director of the Division of Mental Health and Addiction within 15 days of the non-final Order.

If no Objection is filed the Director of the Division of Mental Health and Addiction may serve written notice of intent to review any issue related to the non-final Order of the Administrative Law Judge. The notice will be served on all parties and must identify the issues that the Director intends to review. In reviewing a non-final Order, the Director of the Division of Mental Health and Addiction Services shall base the decision on the evidence in the record.

8.12 Final Order

If no Objection or notice of intent to review is filed, the Director of the Division of Mental Health and Addiction will affirm the non-final Order of the Administrative Law Judge as the agency's final Order. A final Order shall be issued by the Director of the Division of Mental Health and Addiction within 60 days after the latter of:

- the date the Administrative Law Judge's Order was issued;
- the receipt of written comments; or
- the close of oral arguments.

The final Order shall identify any difference between the final Order and Order issued by the Administrative Law Judge, which includes findings of fact or incorporates the findings of fact in the Administrative Law Judge's Order.

If an individual/parent/guardian is not satisfied with the Final Order issued by the Director of the Division of Mental Health and Addiction, the individual/parent/guardian may file a petition for judicial review in accordance with IC 4-21.5-5.

If a lawsuit is filed, the Division of Mental Health and Addiction should direct all inquiries to the FSSA Office of General Counsel.

Section 9. Prior Authorization of Certain Medicaid Services*

Individuals who receive services under a Medicaid HCBS waiver are also eligible to receive traditional services under the "regular" Medicaid program (State Plan services) such as physician services, medications, laboratory services, etc.

States have options in the amount, duration, and scope of the services that are provided under the State Plan. For example, physical therapy available under the State Plan must be authorized by Medicaid prior to its provision. Further, the amount, duration, and scope of the therapy will be limited to address a specific acute condition. State Plan services are primarily restorative or remedial in nature and are not aimed at ameliorating a particular disabling condition.

Some Medicaid services require special authorization through the Medicaid program before they are reimbursable. This is known as "prior authorization" or "PA". PA requirements, forms, etc. are located in Chapter 6 of the "Indiana Health Coverage Programs Provider Manual". Health Care Excel is the Medicaid contractor that is responsible for making PA decisions based on criteria set through Indiana Code, Administrative Rules, and OMPP policy and procedures.

9.1 Health Care Services Requiring Prior Authorization

1. Home Health Nursing Services
   Provided by a Registered Nurse, Licensed Practical Nurse, or Home Health Aide. PA is NOT required if a physician orders the service prior to hospital discharge and the service does not exceed 120 hours within 30 days of discharge. PA is required otherwise if deemed medically reasonable and necessary. Homemaker, chore, sitter/companion services are NOT covered.

2. Occupational, Physical, Speech, and Respiratory Therapies
   All therapies require PA except when a physician orders the service prior to hospital discharge and the service does not exceed 120 hours within 30 days of discharge. Therapy services must be medically necessary and of such a level of complexity and sophistication and the condition of the recipient must be such that the judgment, knowledge, and skills of a qualified therapist are required. Therapy for rehabilitative services is covered no longer than 2 years unless there is a significant change in medical condition requiring more therapy. Therapy services may be authorized longer for children under age 18 on a case-by-case basis. Maintenance therapy is NOT covered.

3. Outpatient Mental Health Services (Services through MRO do not need prior authorization.)

4. Incontinence Supplies

* The provider of the service requests prior authorization of certain Medicaid services.

Incontinence supplies are not available for children younger than 3 years. They are available with PA based on documented medical necessity and limited to $1,950 per rolling year. (See 405 IAC 5-19.)

5. Durable Medical Equipment
   This includes wheelchairs and communication devices. PA is required for all rented or purchased equipment except: cervical collars, back supportive devises such as corsets, hernia trusses, parenteral infusion pumps when used in conjunction with parenteral hyperalimentation, including central venous catheters, eyeglasses, the first 30 days rental of hearing aids or wheelchairs. All repairs of purchased equipment require PA. The anticipated period of need, plus the cost of the item is considered in determining whether the item is rented or purchased. (405 IAC 5-16-3.1)

6. Health Care Transportation
   PA is required for trips exceeding 20 one-way trips per rolling 12-month period EXCEPT emergency ambulance services, transportation to or from a hospital for the purpose of admission or discharge, or patients on dialysis, Trips that are 50 miles or more one way; transportation to or from an out-of-state non-designated area; airline or air ambulance services by a provider located out-of-state in a non-designated area; in-state train or bus services, and family member services all require PA. (See 405 IAC 5-30 for additional information.)

9.2 Prior Authorization Resources

- Indiana Health Coverage Programs Provider Manual, Chapter 6, Prior Authorization
  - Go to website at www.indianamedicaid and click on "Provider Manual" under "Site Favorites".
- Indiana Administrative Code 405 IAC Article 5

Section 10. Documentation Requirements

No SED Waiver services should be provided unless they are authorized by an approved Plan of Care. Providers must have copies of an approved *Notice of Action* for each child for whom they provide an SED Waiver service.

Service documentation should:

- Substantiate the need for services;
- Include entries as appropriate to validate the services rendered;
- Match the date of the claim;
- Match the units of service for each code billed;
- Contain an original, legible signature with a minimum of first initial, last name and title, no printed names, no rubber stamps.

Documentation Errors:

- Missing entries - gaps in service;
- Missing on incomplete dates/times
  - Month/Date/Year
  - AM/PM notations or military time
- Use of pencil or erasable ink
- Incomplete forms/blank form fields
- Forms lacking recipient's name;
- Missing or incomplete staff signatures;
- No documentation of activities/services;
- Use of white-out or correction tape;
- Scratch-outs and write-overs;

Accepted Error Correction Procedure:

- Make single line through entry;
- Write the date and initial above error;
- Enter the corrected information next to the error.

Section 11. Forms

11.1 Level of Care/Eligibility Forms:

- Mental Health Hospital Level of Care Application Form;
- Application for Long-Term Care;
  - http://www.state.in.us/icpr/webfile/formsdiv/51550.pdf
- Notice of Action Form;
  - http://www.state.in.us/icpr/webfile/formsdiv/51547.pdf
- Freedom of Choice Form;
  - http://www.state.in.us/icpr/webfile/formsdiv/51548.pdf
- Transmittal for Medicaid Level of Care Eligibility Form;
  - www.in.gov/fssa/elderly/medicaid/hcbs0007.pdf

11.2 Medicaid Eligibility Forms:

- Form 2400, Application for Food Stamps, Cash Assistance, and Health Coverage; (www.state.in.us/icpr/webfile/formsdiv/30465.pdf)
- Medicaid Waiver Referral to Division of Family and Children (attached);
- Determination of Disability Social Summary State Form 251B (optional). (www.in.gov/icpr/webfile/formsdiv/01111.pdf)

11.3 Plan of Care Forms:

- Provisional Plan of Care Form;
  - http://www.state.in.us/icpr/webfile/formsdiv/51551.pdf
- Plan of Care/Cost Comparison Budget;
  - http://www.state.in.us/icpr/webfile/formsdiv/51549.pdf
- Notice of Action Form
  - http://www.state.in.us/icpr/webfile/formsdiv/51547.pdf

SED Waiver Referral to Division of Family and Children
Central Enrollment Unit
P.O. Box 7213
Indianapolis, IN 46207-7213

Instructions to Wraparound Facilitators:

This form must be submitted to the Central Enrollment Unit (CEU) for a waiver applicant who has a targeted waiver slot. Copies of the following forms must also be attached:

- Application for Long-Term Care;
- Mental Health Hospital Level of Care/Eligibility collaterals and DMHA Eligibility Statement;
- Application for Cash Assistance, Food Stamps, and Health Coverage, Form 2400.

Medicaid applications for individual who are being considered for placement on a waiting list must by filed with the local Office of Family and Children in the county where the individual resides.

Date referral packet is mailed to CEU: _____

Name of waiver applicant	Social Security Number	Date of waiver application
County of residence	Referring Wraparound Provider	Waiver slot # if known
SED Waiver Wraparound Facilitator contact information Name:		
Telephone number(s):		
E-mail:		

☐ Level of Care effective date: _____ ☐ Level of care pending as of this date.

☐ CCB approval date: _____ ☐ CCB pending as of this date.

_____
Signature of Wraparound Facilitator Date

Comments or special circumstances (Include information about a current pending Medicaid application with a local DFC office.